Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

Psychologist

Billing Instructions

September 1998

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Important Contacts

This publication supersedes all previous Psychologist Billing Instructions

APPLYING FOR A PROVIDER

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H,	**(360) 664-0300**
I-O	**(360) 753-4712**
P-Z	**(360) 753-4711**

WHERE DO I SEND HARDCOPY CLAIMS?

Division of Program Support
PO Box 9245
Olympia WA 98507-9245

WHERE DO I CALL IF I HAVE QUESTIONS REGARDING…?

Policy, payments, denials, general questions regarding claims processing, or to request billing instructions?

Provider Inquiry & Relations
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic billing?

Electronic Billing
(360) 753-0318

Definitions

This section defines terms, abbreviations, and acronyms used in these billing instructions that relate to the Medical Assistance Program.

Alcohol & Drug Addiction Treatment & Support Act (ADATSA) - A state-funded program that provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction. Medical assistance ID card will have a *W*.

Authorization – Official approval for department action.

Categorically Needy Program - A program providing maximum benefits to persons whom qualify for Medical Assistance.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - Field offices of the Department of Social and Health Services located in communities throughout the state which administer various services of the department at the community level.

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program. (WAC 388-87-007)

Department or DSHS - The state Department of Social and Health Services.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

General Assistance Unemployable (GAU) - A state-funded program providing medical care to unemployable persons not eligible for or not receiving federal aid.

Limited Casualty-Medically Needy Program (LCP-MNP) - A federally-funded program with a limited scope of medical coverage intended for persons whose income or resources exceed Medicaid's Categorically Needy Program (CNP) eligibility limits.

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With, or assigned to, a primary care provider
- With, or assigned to, a plan; or
- With an independent provider who is responsible for arranging or delivering all contracted medical care. (WAC 388-528-001)

Maximum Allowable - The maximum dollar amount MAA will reimburse to a provider for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

a) Categorically needy program [CNP] as defined in WAC 388-503-0310 and 388-511-1105; or
b) Medically needy program [MNP] as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance Administration (MAA) - The administration within the department of social and health services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

a) 'Part A' covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

b) 'Part B' is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Patient Identification Code (PIC) - An alphanumeric code which is assigned to each Medical Assistance client and which consists of:

- First and middle initials (or a dash (-) if the middle initial is not indicated).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tie breaker).

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider or Provider of Service - An institution, agency, or person:

- Who has signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Psychologist – This is defined as a person with a doctoral degree in clinical psychology from an accredited college or university, or who has been licensed as a psychologist as defined in RCW 18.83.

Remittance and Status Report - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington

(RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. (WAC 388-500-0005)

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual & Customary Fee – This is the maximum rate that may be billed to the department for a certain service or equipment. This is the rate that the provider generally charges non-Medicaid customers.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

General Billing Information

How long do I have to bill?

State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

Eligible Clients: Bill MAA *after* you provide a service(s) to an eligible client. Delivery of a service or product does not guarantee payment.

MAA will not make payment when:

- The service or product is not medically necessary;
- The service or product is not covered by MAA;
- The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; **or**
- MAA is not billed within the 365-day billing limit.

Clients who are not eligible at the time of service, but are later found to be eligible: If you provide services to a person who is *not* eligible for a medical program at the time of service and who is later determined to be eligible, you may be paid by MAA when:

- The service is determined to be medically necessary;
- The service is covered by MAA;
- The service is within scope of care of the medical program for which the client is eligible;
- The client provides you with a medical assistance ID (MAID) card covering the date of service; and
- Your claim is presented within 365 days from the *retroactive* or *delayed certification* date.

Retroactive Certification: An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

Delayed Certification: A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be Medicaid-eligible, and then bill MAA for those services.

Fees

Bill MAA your usual and customary fee (the fee you bill the general public).
MAA's payment will be the lower of the billed charges, or MAA's maximum allowable rate, and is payment in full.

How do I bill for clients who are eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, you must first submit a claim to Medicare within its time limitations. Refer to your Medicare Part B/Medicaid Crossover Billing Instructions.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

Even if you haven't received notification of action by the insurance carrier, MAA's 365-day billing time limit must be met. If MAA denies your claim due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

The third-party carrier codes are listed in the General Information Booklet. You may call the *Coordination of Benefits Section at 1-800-562-6136* if you have further questions.

What records does MAA require that I keep in a client's file?:

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. ***Chart*** means a summary of medical records on an individual patient. ***Record*** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and shall include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor(s) and to the U.S. Department of Health and Human Services upon request. DSHS conducts routine provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying Clients of Their Rights (Advanced Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who is eligible?

Clients presenting Medical Assistance ID Cards with the following identifiers are eligible for psychological evaluations and certifications for psychiatric admission:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP CHIP	Categorically Needy Program - Children's Health Insurance Program
GA-U **No Out of State Care**	General Assistance - Unemployable
LCP-MNP	Limited Casualty Program-Medically Needy Program

Who is not eligible?

Clients presenting Medical ID Cards with the following identifiers are not eligible for psychological evaluations and certifications for psychiatric admission:

Medical Program Identifier	Medical Program
MIP-EMER Hospital Only – **No out-of-state care**	Medically Indigent Program-EMER Hospital Only - No out-of-state care
Family Planning Only	Family Planning Only

What about managed care clients?

Clients whose Medical ID Cards bear an identifier in the HMO column are enrolled in an MAA managed health care plan. Clients with identifiers in the HMO must have services performed at their designated HMO. Call the HMO telephone number located on the client's Medical ID Card. If the client's HMO refers them to you, the HMO must reimburse you for the services.

Coverage

What is covered?

The Medical Assistance Administration (MAA) reimburses licensed psychologists for:

- Psychological evaluations;
- Developmental testing; and
- Neuropsychological testing.

Psychological Evaluation

- A psychological evaluation includes a complete diagnostic history, examination, and assessment. The testing of cognitive processes, visual motor responses, and abstract abilities is accomplished by the combination of several types of testing procedures.
- In order to receive reimbursement for the evaluation, it is expected that the administration of the tests above will generate materials that will be formulated into a report.
  - MAA will reimburse for psychological evaluations using **CPT code 96100**. Up to two (2) units of CPT code 96100 are allowed **without prior authorization per client, per lifetime**.
    - If additional testing is necessary, psychologists must request additional units of CPT code 96100 through the prior authorization process.

Continued on next page…

Developmental Testing

MAA reimburses for developmental testing (CPT codes 96110 and 96111) only when:

- The provider is a board-certified psychologist or neuropsychologist; **and**
- Written/fax prior authorization has been obtained.

Neuropsychological Testing

MAA reimburses for neuropsychological testing (CPT codes 96115 and 96117) only when:

- The provider is a board-certified neuropsychologist; **and**
- Written/fax prior authorization has been obtained

Obtaining Prior Authorization

Send or fax your request for prior authorization to:

MAA – Medical Operations
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

What is not covered?

MAA will ***not*** reimburse for:

- Psychotherapy provided by a psychologist or an ARNP; or
- Continuing care provided by psychologist or by staff employed by the psychologist.

Fee Schedule

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT procedure code descriptions. To view the entire descriptions, please refer to your current CPT book.

Procedure Code	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non-Facility Setting	Facility Setting
96100	Psychological testing	$43.00	$43.00
96105	Assessment of aphasia	Not covered	Not covered
96110	Developmental test, lim	43.00	43.00
96111	Developmental test, extend	43.00	43.00
96115	Neurobehavior status exam	43.00	43.00
96117	Neuropsych test battery	43.00	43.00

Completing the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms. If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**
- **Do not use red ink pens (use black ink for the circled "XO" on crossover claims), highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.
- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.
- **Use upper case** (capital letters) for all alpha characters.
- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink ir not too light or faded.**
- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.
- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field/Description

1a. **Insured's I.D. No.**: Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance ID (MAID) card. This information is obtained from the client's current monthly (MAID) card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
- An alpha or numeric character (tie breaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, PCCM Medicare, Indian Health, Blue Cross, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related to**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: Required. Enter the referring physician or Primary Care Case Manager name. This field *must* be completed for psychology services.

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K).**

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., September 04, 1998 = 090498).

24B. **Place of Service**: Required. This is the only appropriate code for Washington State Medicaid:

Code Number	To Be Used For
3	Office or ambulatory surgery center

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCs) procedure code for the services being billed.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter **1.**

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

Group: Enter the group number assigned by MAA. This is the seven-digit number identifying the entity (i.e., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.